Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		IDENTIFICATION NOMBE	IN.	A. BUILDING	<u> </u>		
		012781		B. WING		04/1	9/2012
NAME OF DE	OVIDED OD SUDDUED	012701	STREET ADDR	ESS, CITY, STA	TE ZIP CODE	04/1	3/2012
NAIVIE OF PR	OVIDER OR SUPPLIER		6931 MAYS\		12, 211 0002		
ADVANTA	GE INFUSION GROUP		FORT WAYN				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF		COMPLETE DATE
IAG			,	ino	DEFICIENCY)		
N 000	Initial Comments			N 000			
	This was an initial St	ate Licensure survey.					
	Survey date: 4/19/12	.					
	Facility #: 012781						
	•	nnett, RN, BSN, PHNS					
	Census: 4						
	Quality Review: Joyo April 23, 20	ce Elder, MSN, BSN, RN 12	I				
N 402	410 IAC 17-10-1(b) L	icensure		N 402			
	home health agency where the parent age other than Indiana. T must: (1) be authorized by conduct business in	license is required for a providing care in Indian ency is located in a state the home health agency the secretary of state to Indiana; and ffice located in Indiana.	a				
	agency failed to ensu	et as evidenced by: and review documents, t ure it functioned as an d agency in Indiana for 1					
	Findings include:						
	Employee A indicated the AlexaCare pharm	a 4-19-12 at 9:30 A.M., d the agency is a branch nacy office in Lenexa, K 20 minutes driving time agency.	s				

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Indiana State Department of Health

	NT OF DEFICIENCIES I OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING	·	04/	19/2012
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ADVANTA	GE INFUSION GROUP		6931 MAYS FORT WAY	VILLE RD NE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
N 402	Continued From page	: 1		N 402			
N 440	the requirement unde Administrative Code) must be located within (120) minutes driving Per "Rand McNally" w home office is 623.3 r minutes away from Fo	17-9-5: A branch officent one hundred and twe time of the parent ager website map, the Alexandriles or 9 hours and 14 port Wayne, Indiana. Have an agreement withow a branch of a Kansandrices in Indiana.	e nty ncy. Care	N 440			
	administration/manag Rule 12 Sec. 1(a) Or furnished, administrat authority for the deleg to the patient care lev (1) clearly set forth in (2) readily identifiable	ganization, services tive control, and lines o gation of responsibility o rel shall be: n writing; and					
		t as evidenced by: eview and interview, th an organizational char					
	Findings include:						
	Review of agency evidence an organiza						
	they are under contra	paperwork and policie					

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
	012781				·	04	/19/2012
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ADVANTA	GE INFUSION GROUP		6931 MAYS FORT WAY	SVILLE RD NE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 442	Continued From page	e 2		N 442			
N 442	410 IAC 17-12-1(b) Fadministration/manag			N 442			
	the operation of the h governing body shall (1) Appoint a qualifie (2) Adopt and period or an acceptable equ (3) Oversee the man the home health ager This RULE is not me Based on document agency failed to ensu	n so functioning, shall nority and responsibility nome health agency. The do the following: and administrator. iically review written by iivalent. agement and fiscal affancy.	aws airs of				
	Findings include:						
	1. Review of agency evidence any policies documentation the go the bylaws.		ewed				
	they are under contra	80 AM, employee A indict with a pharmacy in paperwork and policientarmacy.					
N 449	410 IAC 17-12-1(c)(6 administration/manag) Home health agency gement		N 449			
	also be the supervising nurse required by sulfollowing:	The administrator, whong physician or register osection (d), shall do thome health agency me	ed e				

Indiana State Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04/1	9/2012
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ADVANTA	GE INFUSION GROUP		6931 MAYS	VILLE RD NE, IN 46815			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 449	Continued From page	e 3		N 449			
	all rules and regulatio	ns for licensure.					
	administrator failed to	t as evidenced by: review and interview, the ensure the agency me ons for licensure for 1 c	t all				
	Findings include:						
		failed to ensure the age pendent licensed agen					
	The administrator had an organizational	failed to ensure the age I chart. (See N 440)	ency				
	3. The administrator Governing Body accethe agency. (See N 4	pted policies and bylav	vs for				
	4. The administrator personnel policies. (\$	failed to ensure there w See N 458)	/ere				
		failed to ensure employ berculosis. (See N 464					
		failed to ensure policies emented for control of ses. (See N 470)	5				
	7. The administrator implement a policy re discharge. (See N 48	quiring a 5 day notice of	of				
		failed to ensure patient patient's rights during tl 94)					

Indiana State Department of Health

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04	/19/2012	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE			
ADVANTA	GE INFUSION GROUP		6931 MAYS FORT WAY	VILLE RD NE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 449	Continued From page	e 4		N 449				
14 443	9. The administrator were informed that the exercise his or her rig agency. (See N 496) 10. The administrator were informed of the property treated with 11. The administrator were informed of the regarding treatment or respect for property be services on behalf of subjected to discrimins so. (See N 500) 12. The administrator were informed of the with the state agency furnished by the agental of the with the state agency furnished by the agental of the the care to be furnish to be furnished, the discrete care to be furnished to be furnished, the discrete care informed of the planning of care and the planning of care and the treatment. (See N 500)	failed to ensure patient e patient has a right to patient has a right to this as a patient of the respect. (See N 498) In failed to ensure patient right to have his or her respect. (See N 498) In failed to ensure patient right to voice grievance or regarding the lack of any anyone who is furnish the agency and must not nearly anyone who is furnish the agency and must not regarding treatment or new (See N 502) In failed to ensure patient right to be informed about any changes in the isciplines that will furnish to yof visits to be furnish refailed to ensure patient right to participate in the changes in the care or 155) In failed to ensure patient right to participate in the changes in the care or 155)	nts nts ning ot be ng nts int care nts but care sh ned.	מידי או				
	discharge notice. (Se							

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Indiana State Department of Health STATE FORM

RKZY11 If continuation sheet 5 of 27

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04/1	9/2012
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	<u> </u>	9/2012	
ADVANTA	GE INFUSION GROUP		6931 MAYS FORT WAY	SVILLE RD NE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
N 449	Continued From page	e 5		N 449			
	disclosure of clinical r	e agency policies regar records. (See N 508) r to ensure patients we	-				
	informed of the right t	o access the patient's f the policies regarding					
	accessibility of record						
	18. The administrator failed to ensure patients were informed of the right to be free from verbal, physical, and psychological abuse and to be treated with dignity. (See N 512)		rbal,				
	were informed that the complaints made by the	r failed to ensure patier e agency will investigat he patient or family and ice and resolution of the (4)	te d				
	were informed of the all individuals or legal	r failed to ensure patier right to request a listing entities who have an interest in the agency.	g of				
	were informed of the	nd provided a description					
	periods were 60 days	r failed to ensure the ca in length and medicati n of care. (See N 524)	ons				
		r failed to ensure the tir ministered was identifie					
N 458	410 IAC 17-12-1(f) Ho			N 458			

Indiana State Department of Health

STATE FORM RKZY11 If continuation sheet 6 of 27

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		012781		D. WING		04	/19/2012
	ROVIDER OR SUPPLIER		6931 MAY	DRESS, CITY, STATE 'SVILLE RD YNE, IN 46815	E, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 458	Continued From pag	e 6		N 458			
	employees shall be so All employees caring be subject to Indianal registration required service. Personnel rideliver home health so and shall include docton the job, including the (1) Receipt of job docton (2) Qualifications. (3) A copy of limited IC 16-27-2. (4) A copy of current registration. (5) Annual performation. This RULE is not meassed on document agency failed to ensure the subject to Indianal In	escription. If criminal history pursuant license, certification, once evaluations. Let as evidenced by: Let review and interview, the cure there were personneency with the potential to	shall or ve ho urrent on to ant to or				
	Findings include:						
	Review of agency evidence any person	documents failed to nel policies.					
	indicated they had pr policy manual with are each page and indica	5 PM, the administrator rinted off a copy of a Brinother agency's name cated the agency would procedures but apply the each page.	iggs on use				
N 464	410 IAC 17-12-1(i) H administration/mana			N 464			
	Rule 12 Sec. 1(i) Th	e home health agency	shall				

Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		012781		B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
	AGE INFUSION GROUP			SVILLE RD 'NE, IN 46815			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY F			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 464	Continued From pag	e 7		N 464			
	ensure that all employersons providing cay and contractors having evaluated for tuberout follows: (1) Any person with tuberculosis or a negotial baseline two-step tuberculosis or a negotial tuberculin skin test have during the previous to result was negative. (2) The second step test using the Mantous administered one (1) first tuberculin skin test (3) Any person with: (A) a documented: (i) history of tuberculin previously positive or (iii) completion of treat (B) newly positive results; must have one (1) chiagnosis of tuberculin tuberculin test; must have one (1) chiagnosis of tuberculin test; must have one (1) chiagnosis of tuberculin test; must have one (1) chiagnosis of tuberculin test; (A) be completed and (B) include, at a minusing the Mantoux massay unless the indivision (3). (5) Any person having tuberculosis evaluating the Mantoux massay unless the indivision (3). (5) Any person having tuberculosis evaluating the Mantoux massay unless the indivision (3).	oyees, staff members, are on behalf of the ager and direct patient contact allosis and documentation an egative history of a pative test result must have called a quantiferon-TB assay has documentation that as been applied at any welve (12) months and of a two-step tuberculing the tothree (3) weeks after est was administered. Ilosis; Ilosis; Ilosis; Ilosis test result for tuberculing atment for tuberculosis; Ilosis to the tuberculosis; Interest rediograph to exclusion set in the tuberculosis set in the tuberculosis. Interest rediograph to exclusion set in tuberculosis set in tu	t are on as ave a the t a time the n skin r the osis; or kin de a ening test TB				

Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S	
				A. BUILDING			
		012781		B. WING		n ₄	1/19/2012
NAME OF DE	ROVIDER OR SUPPLIER	1	STREET ADD	RESS, CITY, STAT	TE. ZIP CODE	, ,	
NAIVIE OF FE	NOVIDER OR SUFFLIER		6931 MAYS	, ,	12, 211 0002		
ADVANTA	AGE INFUSION GROUP			NE, IN 46815			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FUR R LSC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
					DEI TOTENO	.,	
N 464	Continued From page	ge 8		N 464			
	showing that any pe (A) working for the (B) having direct pa	home health agency; or atient contact;					
		finding on a tuberculosis he previous twelve (12)	3				
	agency failed to ens	I file review and interview sure employees were sulosis for 1 of 2 employe he potential to affect all t	ee				
	Findings include:						
	· ·	hire date 2/22/12, failed sis evaluation testing for					
	they called employe tuberculosis evaluat	00 PM, employee A indice B to bring a copy of tion testing to the agency byee B has not provided f today.	y, but				
N 470	410 IAC 17-12-1(m) administration/mana	Home health agency agement		N 470			
	be written and imple	Policies and procedures emented for the control case in compliance with and state laws.					
	agency failed to ens	net as evidenced by: and review of document sure policies were writter					

Indiana State Department of Health

TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	042704		1		0.44	10/0040
DOVIDED OD SUDDI IED	012781	STREET ADDI	RESS CITY STA	TE ZIP CODE	04/	19/2012
ROVIDER OR SUPPLIER			, ,	12, 211 3352		
GE INFUSION GROUP						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETE DATE
Continued From page	9		N 470			
		to				
Findings include:						
evidence any policies	related to the control of					
indicated they had pri policy manual with an each page and indica that for policies and p	inted off a copy of a Bri nother agency's name o ited the agency would u rrocedures but apply the	in ise				
410 IAC 17-12-2(i) an improvement	nd (j) Q A and performa	nce	N 488			
develop and impleme of discharge of servic legal representative, of responsible for the pa	ent a policy requiring a rete to the patient, the patient, the patient or other individual attent's care at least five	notice tient's e (5)				
subsection (i) of this r following circumstanc (1) The health, safety home health agency's immediate and significagency continued to patient. (2) The patient refuse services. (3) The patient's services.	rule does not apply in theses: y, and/or welfare of the semployees would be a cant risk if the home he provide services to the esthe home health agentices are no longer	at ealth ency's				
	Continued From page diseases for 1 of 1 ag affect all the agency's Findings include: 1. A review of agency evidence any policies communicable disease have any policies and policy manual with an each page and indicath for policies and pown agency label on 410 IAC 17-12-2(i) ar improvement Rule 12 Sec. 2(i) A h develop and impleme of discharge of service legal representative, or responsible for the pacalendar days before (j) The five (5) day possible for the pacalendar days before (j) The five (5) day possible for the pacalendar days before (j) The five (5) day possible for the pacalendar days before (j) The five (5) day possible for the pacalendar days before (j) The five (5) day possible for the pacalendar days before (j) The patient for the pacalendar days before (j) The patient refuse services. (j) The patient refuse services. (k) The patient refuse services.	O12781 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION OR LSC IDENTIFY INFORMATION OR LSC IDENTIFYING INFORMATION OR LSC IDENTIF	STREET ADDI STREET ADDI SOUTH AND STREET AD	ROVIDER OR SUPPLIER AGE INFUSION GROUP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 diseases for 1 of 1 agency with the potential to affect all the agency's staff and patients. Findings include: 1. A review of agency documents failed to evidence any policies related to the control of communicable diseases. The agency does not have any policies. 2. On 4/19/12 at 2:15 PM, administrator indicated they had printed off a copy of a Briggs policy manual with another agency's name on each page and indicated the agency would use that for policies and procedures but apply their own agency label on each page. 4 10 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement	ROWIDER OR SUPPLIER ROWIDER SPANDARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 diseases for 1 of 1 agency with the potential to affect all the agency's staff and patients. Findings include: 1. A review of agency documents failed to evidence any policies related to the control of communicable diseases. The agency does not have any policies related to the control of communicable diseases. The agency would use that for policies and procedures but apply their own agency label on each page. 410 IAC 17-12-2(i) and (i) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (i) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The patient's services are no longer reimbursable based on applicable reimbursement	A BULIDING B. WING CASH INFUSION GROUP STREET ADDRESS, CITY, STATE, ZIP CODE S931 MAYSVILLE RD (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) COntinued From page 9 diseases for 1 of 1 agency with the potential to affect all the agency's staff and patients. Findings include: 1. A review of agency documents failed to evidence any policies related to the control of communicable diseases. The agency does not have any policies related to the control of communicable diseases. The agency would use that for policies and procedures but apply their own agency label on each page. 410 IAC 17-12-2(i) and (i) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (i) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (i) The health, safety, and/or welfare of the home health agency's services. (3) The patient's services are no longer emimbursement

Indiana State Department of Health

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Indiana State Department of Health

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04/4	0/2042
NAME OF PR	ROVIDER OR SUPPLIER	012761	STREET ADD	 RESS, CITY, STA	TE. ZIP CODE	04/1	9/2012
	GE INFUSION GROUP		6931 MAYS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
N 488	Continued From page	e 10		N 488			
	assist the patient folic (4) The patient no lor regulatory criteria, surorder, and the home I patient of community patient following discharge of the patient following as the patient following as the patient following as the patient following include: 1. A review of agency evidence any policies 2. On 4/19/12 at 11:: indicated they are under the patient following include:	nger meets applicable ch as lack of physician' health agency informs to resources to assist the narge. It as evidenced by: Ind review of documents lop and implement a poce of discharge for 1 of notial to affect all the agency documents failed to a related to discharge. 30 AM, employee A der contract with a phala he paperwork and polician's resources.	s the s, the blicy 1 ency's				
N 494	410 IAC 17-12-3(a)(1)&(2) Patient Rights		N 494			
	legal representative h of the patient's rights communication. The I protect and promote t and shall do the follow (1) Provide the patie the patient's right: (A) in advance of furior (B) during the initial e initiation of treatment.	ent with a written notice nishing care to the patie evaluation visit before the	med us of ust ghts of ent;				

Indiana State Department of Health

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04	/19/2012
NAME OF PE	ROVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STATE	E, ZIP CODE	•	
ADVANTA	GE INFUSION GROUP			SVILLE RD 'NE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 494	Continued From page	e 11		N 494			
	complied with the red	quirements of this section	on.				
	records, the agency to were informed of the initial visit for 4 of 4 repotential to affect all. Findings include: 1. Review of agency evidence a patient's records 1-records 1	and review of documents failed to ensure patients patient's rights during the ecords reviewed with the agency's patients.	he h				
N 496	410 IAC 17-12-3(b) F	Patient Rights		N 496			
	his or her rights as a agency as follows: (1) The patient's far may exercise the pat law. This RULE is not me Based on interview a records, the agency twere informed that the	ent has the right to exerpatient of the home here mily or legal representations is rights as permitte et as evidenced by: and review of document failed to ensure patients are patient has a right to other saids as a patient of the	alth ive d by s and				

Indiana State Department of Health

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI					(X3) DATE SURVEY COMPLETED		
7.1.2.2.1.0		IDENTIFICATION NOME	EK.	A. BUILDING		1		
		012781		B. WING		04/1	19/2012	
NAME OF DE	ROVIDER OR SUPPLIER	012101	STREET ADD	RESS, CITY, STA	TE ZIP CODE		13/2012	
NAME OF PR	ROVIDER OR SUPPLIER		6931 MAYS	, ,	(I, Z.II GGBL			
ADVANTA	ADVANTAGE INFUSION GROUP			NE, IN 46815				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FUR R LSC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF		COMPLETE DATE	
					DEFICIENCY)			
N 496	Continued From pag	je 12		N 496				
	agency for 4 of 4 red	cords reviewed with the						
		the agency's patients.						
	Findings include:							
	1 Review of agency	y documents failed to						
	evidence a patient's							
	2 Clinical records 1	-4 failed to evidence the						
		l a patient's rights docun						
	3. On 4/19/12 at 11	:30 AM, employee A ind	icated					
		act with a pharmacy in						
		e paperwork and policie						
		harmacy. The agency of						
		ge patients as the agend aid, Medicare, or insuran						
		nacy will pay Advantage						
	providing nurses.	, , ,						
N 498	410 IAC 17-12-3(b)(2)(A) Patient Rights		N 498				
	Rule 12 (h). The nat	ient has the right to exe	rcise					
	. ,	patient of the home he						
	agency as follows:							
		s the right to the following	g:					
	` '	property treated with						
	respect.							
	This RULE is not m							
		and review of document						
		failed to ensure patients e right to have his or her						
		respect for 4 of 4 recor						
		otential to affect all the						
	agency's patients.							
	Findings include:							
	1. Review of agence	v documents failed to						

Indiana State Department of Health

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04/19/2	2012
NAME OF PR	OVIDER OR SUPPLIER	0.2.0.	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	1 04/13/2	2012
ADVANTA	ADVANTAGE INFLISION GROUD			VILLE RD NE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
N 498	Continued From page	e 13		N 498			
	evidence a patient's r	ights document.					
	evidence a patient's rights document. 2. Clinical records 1-4 failed to evidence the patient had received a patient's rights document. 3. On 4/19/12 at 11:30 AM, employee A indicated they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses.						
N 500	410 IAC 17-12-3(b)(2)(B) Patient Rights		N 500			
	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. This RULE is not met as evidenced by: Based on interview and review of documents and records, the agency failed to ensure patients were informed of the right to voice grievances regarding treatment or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and must not be subjected to discrimination or reprisal for doing so for 4 of 4 records reviewed with the potential to affect all the agency's patients.		alth g: r ding no is				
			ning ot be ng so				
	Findings include:						

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Indiana State Department of Health

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB 012781			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/19/2012			
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		10/2012		
ADVANTA	ADVANTAGE INFUSION GROUP			6931 MAYSVILLE RD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
N 500	Continued From page	e 14		N 500					
	Review of agency evidence a patient's r								
		4 failed to evidence the a patient's rights docun	nent.						
	they are under contra another state and the all provided by the ph not admit or discharg not be billing Medicai	30 AM, employee A indict with a pharmacy in a paperwork and policie parmacy. The agency of a patients as the agency of the discourant of the page of t	s are loes cy will ce,						
N 502	410 IAC 17-12-3(b)(2	(C) Patient Rights		N 502					
	 410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exerci his or her rights as a patient of the home healt agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a hor health agency. 		alth g:						
	records, the agency f were informed of the	nd review of documents failed to ensure patients right to place a compla regarding treatment or ncy for 4 of 4 records	int						
	Findings include:								
	Review of agency evidence a patient's r								
	2. Clinical records 1-4	4 failed to evidence the							

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04/19	9/2012
NAME OF PR	OVIDER OR SUPPLIER	0.2.0.	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	<u> </u>	5/ 2 012
ADVANTA	GE INFUSION GROUP		6931 MAYS	VILLE RD NE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
N 502	Continued From page		N 502				
	3. On 4/19/12 at 11:3 they are under contra another state and the all provided by the ph not admit or discharge not be billing Medicaid	a patient's rights documed a patient's rights documed a Market A indict with a pharmacy in paperwork and policies armacy. The agency depatients as the agency depatients as the agency depatient as the agency will pay Advantage for the patient and the pati	cated s are loes cy will ce,				
N 504	his or her rights as a pagency as follows: (2) The patient has (D) Be informed about and of any changes in follows: (i) The home health patient in advance of (AA) disciplines that (BB) frequency of visit furnished. This RULE is not me Based on interview and records, the agency fawere informed of the the care to be furnished to be furnished, the dicare, and the frequent for 4 of 4 records reviaffect all the agency's	ent has the right to exer- patient of the home head the right to the following the care to be furnish agency shall advise the the: will furnish care; and sits proposed to be It as evidenced by: and review of documents ailed to ensure patients right to be informed aboved, any changes in the isciplines that will furnish cy of visits to be furnish ewed with the potential	alth g: hed, ed as e s and cout care sh	N 504			
	Findings include: 1. Review of agency evidence a patient's r						

Indiana State Department of Health

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM 012781			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				B. WING		04/	19/2012	
	ROVIDER OR SUPPLIER		6931 MAYS	STREET ADDRESS, CITY, STATE, ZIP CODE 6931 MAYSVILLE RD FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
N 504	Continued From page	e 16		N 504				
	patient had received 3. On 4/19/12 at 11:3 they are under contra another state and the all provided by the ph not admit or discharg not be billing Medicai	4 failed to evidence the a patient's rights docunt 30 AM, employee A indicact with a pharmacy in a paperwork and policie narmacy. The agency of the patients as the agency will pay Advantage	nent. icated s are does cy will ace,					
N 505	410 IAC 17-12-3(b)(2	2)(D)(ii) Patient Rights		N 505				
	his or her rights as a agency as follows: (2) The patient has (D) Be informed about and of any changes it follows: (ii) The patient has the planning of the care. shall advise the patie participate in planning (AA) The care or tree (BB) Changes in the This RULE is not measured by the planning of care and treatment for 4 of 4 respectives.	e care or treatment.	alth ig: shed, ed as i the cy ht to s and s ie					
	Findings include:							
	Review of agency	documents failed to						

Indiana State Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION NI		(X1) PROVIDER/SUPPLIER/				(X3) DATE SURVEY COMPLETED	
	BEITH 16 WHOW		EK.	A. BUILDING			
		012781		B. WING		n .	4/19/2012
NAME OF BE	201/1050 00 01 1001 150	012701	STREET ADDE	RESS, CITY, STA	TE ZIR CODE		+/ 19/2012
NAME OF PE	ROVIDER OR SUPPLIER				ile, zir code		
ADVANTA	ADVANTAGE INFUSION GROUP			VILLE RD NE, IN 46815			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX		CY MUST BE PRECEDED BY FU LISC IDENTIFYING INFORMATI		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
TAG	REGULATORT OR	LISC IDENTIFTING INFORMATI	ION)	TAG	DEFICIENCY		D/(IE
N 505	Continued From pag	je 17		N 505			
	evidence a patient's	rights document.					
	panama	g					
	2. Clinical records 1-	-4 failed to evidence the					
	patient had received	a patient's rights docun	nent.				
		30 AM, employee A ind	icated				
		act with a pharmacy in					
		e paperwork and policie harmacy. The agency o					
		ge patients as the agency					
		nid, Medicare, or insuran	•				
	_	acy will pay Advantage					
	providing nurses.	, , ,					
N 506	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights		N 506			
		ient has the right to exe					
		patient of the home he	alth				
	agency as follows:						
		s the right to the following out the care to be furnis					
	· · ·	in the care to be furnish					
	follows:	in the dare to be farmen	00 00				
	(iii) The home health	h agency shall advise th	e				
	patient of any chang	e in the plan of care,					
	including reasonable	e discharge notice.					
	TI: DINE: :						
	This RULE is not mo	et as evidenced by: and review of document	s and				
		failed to ensure patients	· · · ·				
		right to a reasonable	,				
		4 of 4 records reviewed	with				
		t all the agency's patien					
	Findings include:						
	1. Review of agency	y documents failed to					
	evidence a patient's						
		-					
	2. Clinical records 1-	-4 failed to evidence the					

Indiana State Department of Health

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANO			EK:	A. BUILDING		CONII	LETED
		012781		B. WING	 -		4/19/2012
		012701	CTDEET ADD	DECC CITY CTA	TE 710 CODE	0	4/19/2012
NAME OF PF	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
ADVANTAGE INFUSION GROUP			6931 MAYS	NE, IN 46815			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FU LISC IDENTIFYING INFORMAT		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
TAG	REGULATORT OR	LISC IDENTIFTING INFORMAT	ION)	TAG	DEFICIENCY		B/(IE
N 506	Continued From pag	je 18		N 506			
	patient had received	a patient's rights docum	nent.				
	3 On 4/10/12 at 11:	30 AM, employee A ind	icated				
		act with a pharmacy in	icated				
		e paperwork and policie	s are				
		harmacy. The agency of					
		ge patients as the agence					
		nid, Medicare, or insurar					
	_	acy will pay Advantage					
	providing nurses.	., ., .,					
N 508	410 IAC 17-12-3(b)(2)(E) Patient Rights		N 508			
	Rule 12 Sec. 3(b)(2	2)(F)					
		s the right to exercise hi	s or				
		nt of the home health ag					
	as follows:	•	,				
	(2) The patient has	s the right to the following	g:				
	(E) Confidentiality	of the clinical records					
	,	ome health agency. Th					
		shall advise the patient					
		s and procedures regard	ling				
	disclosure of clinical	records.					
	T						
	This RULE is not me						
		and review of document					
		failed to ensure patients right to confidentiality of					
		e right to confidentiality the agency policies regar					
		records for 4 of 4 record					
		tential to affect all the	45				
	agency's patients.	to anot an inc					
	3, . ,						
	Findings include:						
	1. Review of agency	y documents failed to					
	evidence a patient's						
	,	-					
	2. Clinical records 1-	-4 failed to evidence the					
	patient had received	a patient's rights docum	nent.				

STATE FORM RKZY11 If continuation sheet 19 of 27

Indiana State Department of Health

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM 012781			(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				B. WING		04	/19/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6931 MAYSVILLE RD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 508	Continued From page	e 19		N 508				
	they are under contra another state and the all provided by the ph not admit or discharg not be billing Medical	30 AM, employee A ind act with a pharmacy in a paperwork and policienarmacy. The agency ope patients as the agencial, Medicare, or insuraracy will pay Advantage	es are does cy will nce,					
N 510	510 410 IAC 17-12-3(b)(3) Patient Rights			N 510				
	her rights as a patient as follows: (3) The patient or patient to patient to patient under In patient's clinical reconsceptions apply. The advise the patient or representative of its patient.	the right to exercise hist of the home health against the second attent's legal representantiana law to access the rds unless certain the home health agency	gency ative e shall					
	records, the agency to were informed of the clinical records and conditions accessibility of records.	and review of document failed to ensure patients right to access the pati of the policies regarding	s ent's					
	Findings include:							
	Review of agency evidence a patient's i							
		4 failed to evidence the a patient's rights docun						

Indiana State Department of Health

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMB 012781			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED . 04/19/2012		
				B. WING				
NAME OF PE	ROVIDER OR SUPPLIER	0.2.0.	STREET ADD	RESS, CITY, STATE	, ZIP CODE	1 04	13/2012	
ADVANTA	GE INFUSION GROUP		6931 MAYSVILLE RD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
N 510	Continued From pag	ge 20		N 510				
	they are under contranother state and the all provided by the p not admit or dischard not be billing Medica	:30 AM, employee A ind ract with a pharmacy in e paperwork and policie harmacy. The agency of ge patients as the agency aid, Medicare, or insurar nacy will pay Advantage	es are does cy will nce,					
N 512	410 IAC 17-12-3(b)(4) Patient Rights			N 512				
	her rights as a patier as follows:	s the right to exercise hint of the home health ages the right to be as followal, physical, and	gency					
	records, the agency were informed of the physical, and psycho- treated with dignity for	et as evidenced by: and review of document failed to ensure patients e right to be free from ve blogical abuse and to be for 4 of 4 records review affect all the agency's	s erbal, e					
	Findings include:							
	Review of agency evidence a patient's	y documents failed to rights document.						
		-4 failed to evidence the la patient's rights docur						
		:30 AM, employee A ind act with a pharmacy in	icated					

			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	012781		B. WING		04/	/19/2012	
OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
GE INFUSION GROUP			6931 MAYSVILLE RD FORT WAYNE, IN 46815				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FL		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETE DATE	
Continued From page	e 21		N 512				
all provided by the ph not admit or discharg not be billing Medicai	narmacy. The agency of e patients as the agency d, Medicare, or insuran	loes cy will ce,					
410 IAC 17-12-3(c) P	atient Rights		N 514				
following: (1) Investigate com the patient's family or regarding either of the (A) Treatment or car furnished. (B) The lack of resp by anyone furnishing home health agency. (2) Document both complaint and the res This RULE is not me Based on interview a records, the agency f were informed that th complaints made by t document the existen complaint for 4 of 4 re potential to affect all t Findings include: 1. Review of agency evidence a patient's r 2. Clinical records 1-4	plaints made by a patient legal representative ender following: The services on behalf of the services of the solution of the complaint of the services of the services of documents alled to ensure patients agreed will investigate the patient or family and the services of the services o	operty ne t. s and ste d e e					
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page another state and the all provided by the ph not admit or discharg not be billing Medicai but rather the pharma providing nurses. 410 IAC 17-12-3(c) F Rule 12 Sec. 3(c) (c) The home healt following: (1) Investigate com the patient's family or regarding either of the (A) Treatment or cal furnished. (B) The lack of resp by anyone furnishing home health agency. (2) Document both complaint and the res This RULE is not me Based on interview a records, the agency f were informed that th complaints made by the document the exister complaint for 4 of 4 re potential to affect all the Findings include: 1. Review of agency evidence a patient's r 2. Clinical records 1-4	O12781 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL REGULATORY OR LSC IDENTIFYING INFORMATI Continued From page 21 another state and the paperwork and policie all provided by the pharmacy. The agency onto admit or discharge patients as the agency not be billing Medicaid, Medicare, or insurant but rather the pharmacy will pay Advantage providing nurses. 410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's proby anyone furnishing services on behalf of thome health agency. (2) Document both the existence of the complaint and the resolution of the complain. This RULE is not met as evidenced by: Based on interview and review of documents records, the agency failed to ensure patients were informed that the agency will investigat complaints made by the patient or family and document the existence and resolution of the complaint for 4 of 4 records reviewed with the potential to affect all the agency's patients. Findings include: 1. Review of agency documents failed to evidence a patient's rights document.	TOURISH TOURIS	TOURIDER OR SUPPLIER GE INFUSION GROUP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 21 another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses. 410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. This RULE is not met as evidenced by: Based on interview and review of documents and records, the agency failed to ensure patients were informed that the agency will investigate complaints made by the patient or family and document the existence and resolution of the complaint for 4 of 4 records reviewed with the potential to affect all the agency's patients. Findings include: 1. Review of agency documents failed to evidence a patient's rights document. 2. Clinical records 1-4 failed to evidence the	FORRECTION O12781 STREET ADDRESS, CITY, STATE, ZIP CODE	TOMPLE OF SUPPLIER O12781 STREET ADDRESS, CITY, STATE, ZIP CODE 831 MANY SYLLE RD FORT WAYNE, IN 48815 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 21 another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses. 410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. This RULE is not met as evidenced by: Based on interview and review of documents and records, the agency failed to ensure patients were informed that the agency will investigate complaints made by the patient or family and document the existence and resolution of the complaint for 4 of 4 records reviewed with the potential to affect all the agency's patients. Findings include: 1. Review of agency documents failed to evidence a patient's rights document. 2. Clinical records 1-4 failed to evidence the	

Indiana State Department of Health

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		012781		B. WING		04	/19/2012		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	, ZIP CODE				
ADVANTA	ADVANTAGE INFUSION GROUP			6931 MAYSVILLE RD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT			PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
N 514	Continued From pag	e 22		N 514					
	they are under contranother state and the all provided by the protraction admit or dischargenot be billing Medica	30 AM, employee A indicact with a pharmacy in e paperwork and policie harmacy. The agency oge patients as the agencid, Medicare, or insuran acy will pay Advantage	s are loes cy will ice,						
N 516	410 IAC 17-12-3(d) I	Patient Rights		N 516					
	Rule 12 Sec. 3(d) (d) The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency as defined in 42 CFR § 420.201, 42 CFR § 420.202, and 42 CFR § 420.206, in effect on July 1, 2005.								
	records, the agency were informed of the all individuals or lega ownership or control	and review of documents failed to ensure patients right to request a listing all entities who have an interest in the agency for differential to at	g of or 4						
	Findings include:								
	Review of agency evidence a patient's	documents failed to rights document.							
		4 failed to evidence the a patient's rights docun							
	3. On 4/19/12 at 11:	30 AM, employee A indi	cated						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		ER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	012781				04/	19/2012
ROVIDER OR SUPPLIER	012701	STREET ADD	I RESS, CITY, STAT	TE, ZIP CODE	04/	13/2012
GE INFUSION GROUP						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE
Continued From page		N 516				
they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses.						
410 IAC 17-12-3(e) P	atient Rights		N 518			
distribute written infor advance, concerning directives, including a state law. The home advanced directives in the time of the first ho information is furnished. This RULE is not me Based on interview are agency failed to ensure the agency's policies provided a description 4 of 4 records reviewed.	mation to the patient, in its policies on advance description of applicate health agency may furniformation to a patient ome visit, as long as the ed before care is provided to a evidenced by: Indirection of application of application advance directives and applicable state lawed with the potential to	ole nish at e led. ue oed of and v for				
patient had been notif	fied of the agency's pol	icies				
patient had been notified of the agency's policies on advance directives and provided a description of applicable state law. 2. On 4/19/12 at 11:30 AM, employee A indicated they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does						
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR INTEGRAL ATORY OR INTEG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION OR LSC ID	STREET ADDI 6931 MAYS FORT WAY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses. 410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. This RULE is not met as evidenced by: Based on interview and review of records, the agency failed to ensure patients were informed of the agency spolicies on advance directives and provided a description of applicable state law for 4 of 4 records reviewed with the potential to affect all the agency's patients. Findings include: 1. Clinical records 1-4 failed to evidence the patient had been notified of the agency's policies on advance directives and provided a description of applicable state law. 2. On 4/19/12 at 11:30 AM, employee A indicated they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does	GE INFUSION GROUP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients as the agency will not be billing Medicaid, Medicare, or insurance, but rather the pharmacy will pay Advantage for providing nurses. 410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. This RULE is not met as evidenced by: Based on interview and review of records, the agency failed to ensure patients were informed of the agency's policies on advance directives and provided a description of applicable state law for 4 of 4 records reviewed with the potential to affect all the agency's patients. Findings include: 1. Clinical records 1-4 failed to evidence the patient had been notified of the agency's policies on advance directives and provided a description of applicable state law. 2. On 4/19/12 at 11:30 AM, employee A indicated they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does	STREET ADDRESS, CITY, STATE, ZIP CODE 831 MAYSVILLE RD FORT WAYNE, IN 46815 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS	OW/DIGEN OR SUPPLIER GE INFUSION GROUP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does not admit or discharge patients were informed of the agency, spolicies on advance directives information to the patient at the time of the first home visit, as long as the information is furnished before care is provided. Findings include: 1. Clinical records 1-4 failed to evidence the patient had been notified of the agency's patients. The agency does on advance directives and provided a description of applicable state law. The home health agency may furnish advanced firectives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Findings include: 1. Clinical records 1-4 failed to evidence the patient had been notified of the agency's patients. Findings include: 2. On 4/19/12 at 11:30 AM, employee A indicated they are under contract with a pharmacy in another state and the paperwork and policies are all provided by the pharmacy. The agency does

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		012781		B. WING		04	/19/2012	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	T ADDRESS, CITY, STATE, ZIP CODE				
ADVANTAGE INFLISION GROUP				931 MAYSVILLE RD ORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
N 518 Continued From page 24				N 518				
	_	d, Medicare, or insuran acy will pay Advantage						
N 524	410 IAC 17-13-1(a)(1) Patient Care			N 524				
	Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on clinical record review and interview, the Registered Nurse failed to ensure the care periods were 60 days in length and medications were listed on the plan of care for 3 of 4 clinical records reviewed with the potential to affect all the agency's patients. (# 1, 2, and 3)		ome killed ired. st erral. f					

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
						04	04/19/2012	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE	E, ZIP CODE	0-	71372012	
ADVANTA	GE INFUSION GROUP			SVILLE RD 'NE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	(X5) COMPLETE DATE		
N 524	Continued From page 25			N 524				
	 On 4/19/12 at 12:15 PM, employee A indicated the care periods are provided thro which pharmacy the agency contracts and receives orders from. The pharmacy Direct Nursing indicated they are not a Medicare certified facility so they do not follow OASIS dates, just a 60 day period. Clinical record #1, start of care date 1/14 contained a Plan of Treatment for the care period beginning 2/2 should have ended on 4/25/12. Physician orders dated 1/12/12 indicate patient was to receive the medication IVIG 0 g/kg daily for 2 days. The Plan of Treatment 		or of /11, period 26/12 ed the 0.4					
	infused. 3. Clinical record #2. contained a Plan of T 2/17-4/17/12. The ca	name of the medication , start of care date 2/17 Treatment for the care pare period beginning 2/	7/12, period					
	contained a Plan of T	, start of care date 4/14 reatment for the care pare period beginning 2/	period					
N 610	410 IAC 17-15-1(a)(7) Clinical Records			N 610				
	Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.							
	This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
012781		012781		B. WING		04/19/2012		
NAME OF PROVIDER OR SUPPLIER STREET			STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ADVANTACE INCLISION COOLID				MAYSVILLE RD WAYNE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 610	Continued From page 26			N 610				
N 610	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		N 610					

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